



PREAUTHORIZATION AND CONCURRENT REVIEW REQUIREMENTS

For certain services, your doctor must obtain prior approval. Below is a list of those services:

- Inpatient hospital admission including the principal scheduled procedure(s) and the length of stay
- Outpatient surgical or ambulatory surgical services
- Spinal surgery
- All Chiropractic services including office visits and manipulations greater than 8 visits
- Psychological testing and psychotherapy, repeat interviews, and biofeedback; except when any service is part of a preauthorized or exempt rehabilitation program
- External and implantable bone growth stimulators
- Chemonucleolysis
- Myelograms, discograms, or surface electromyograms
- Repeat individual diagnostic study, with a fee established in the current Medical Fee Guideline of greater than \$350
- Work hardening and work conditioning services provided in a facility that has not been approved for exemption by the Commissioner.
- Rehabilitation programs to include outpatient medical rehabilitation and chronic pain management/interdisciplinary pain rehabilitation
- Chronic pain management/interdisciplinary pain rehabilitation
- Durable medical equipment (DME) in excess of \$500 per item (either purchase or expected cumulative rental) and all transcutaneous electrical nerve stimulators (TENS) units
- Nursing home, convalescent, residential, and all home health care services and treatments
- Chemical dependency or weight loss programs
- Investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care
- Physical and occupational therapy which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:
 - (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
 - (i) Modalities, both supervised and constant attendance;
 - (ii) Therapeutic procedures, excluding work hardening and work conditioning;
 - (iii) Orthotics/Prosthetics Management;
 - (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and
 - (B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;
 - (C) Except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following the date of injury or a preauthorized surgical intervention-
- Intrathecal drug delivery system

- Refills of an intrathecal drug delivery system with drugs excluded from the closed formulary, with annual preauthorization required thereafter.
- Refills of an intrathecal drug delivery system whenever (A) medications, dosage or range of dosages or the drug regime differs from the medications, dosage or range of dosages or the drug regime previously authorized for that prescribing doctor; or (B) there is a change in prescribing doctor.
- For injuries occurring on or after 09.01.11, drugs not included in the closed formulary.
- For injuries occurring on or after 09.01.11, drugs identified with a status of “N” in the current edition of the *ODG Treatment in Workers’ Comp (ODG)/Appendix A, ODG Workers’ Compensation Drug Formulary* and any updates
- For injuries occurring on or after 09.01.11, any compound that contains a drug identified with a status of “N” in the current edition of the *ODG Treatment in Workers’ Comp (ODG)/Appendix A, ODG Workers’ Compensation Drug Formulary* and any updates
- Treatments and services that exceed or are not addressed in the ODG treatment guidelines and are not contained in a preauthorized treatment plan

Some treatment will be reviewed as you receive it. Below is a list of those services:

- Inpatient length of stay
- Work hardening or work conditioning services
- Physical and Occupational Therapy services
- Investigational or experimental services or use of devices
- Chronic Pain Management/Interdisciplinary Pain Rehabilitation programs
- Required Treatment Plans

Emergency treatment and services and life-threatening or post stabilization treatment are exempt from preauthorization review.



How to submit a preauthorization or concurrent review request

Utilization review requests may be submitted by telephone or facsimile by contacting the Utilization Review Department at the following numbers.

Telephone: 800-664-2276

Fax: 603-334-0329

You may use the following form, as desired, to facilitate the handling of your preauthorization or concurrent review request.



CONFIDENTIAL INFORMATION

TO: LIBERTY MUTUAL MANAGED CARE, INC. Fax #: 603-334-0329

FROM: _____ **PHONE #:** _____

RE: TEXAS WORKERS' COMPENSATION PREAUTHORIZATION OR CONCURRENT REVIEW REQUEST

Patient Information:

Name: _____ Claim Number: _____

Date of Birth: _____ SS#: _____ Date of Injury: _____

Request Type (Circle one)	Treatment Setting (Circle one)	Treatment Type (Circle one)
Initial request for utilization review	23 hr. Observation	DME > \$500
URAC Reconsideration (provider contact)	Ambulatory Surgical Center	Medical
Reconsideration of an adverse determination	Home	Occupational or Physical Therapy
Extension of certified treatment	Inpatient	Psychiatric
Resubmission of request	Outpatient Facility	Repeat Diagnostic Test > \$350
(Date of initial submission- _____)	Provider's Office	Surgical
		Other- _____

Primary diagnosis-ICD 9 code: _____

Description: _____

Principal procedure CPT code: _____

Description: _____

Expected Treatment Start Date: _____ **Expected Treatment Completion Date:** _____

Attending physician name & specialty: _____

Address: _____

Phone: _____

Servicing provider or facility name: _____

Address: _____

Phone: _____

Comments/Additional Information: _____

Supporting medical information attached: (Select one) YES _____ NO _____

FOR TREATMENT AND SERVICES WITH FREQUENCY AND DURATION COMPONENTS, PLEASE COMPLETE THE FOLLOWING:

Units (Number of visits/days visits requested) _____ **Frequency** _____ **Duration** _____
Example: Units 12 Frequency 3 x week Duration 4 weeks

Date of Prescription: _____

Date of Initial Evaluation/Progress or Clinical Notes: _____